

Increasing Access to SSA Disability Benefits... Promising Practices for SSI Outreach

Homelessness costs.

The statement is not new or radical. The costs of homelessness are great for individuals as well as for states and communities. Estimates are that \$4 billion is spent annually on homelessness by local and state governments, health care providers, correctional facilities, emergency shelters, and other providers of services to people who are homeless.¹

What is new and radical is finding a way to recover and/or avoid some of those financial and social costs.

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are two such ways to reduce the burden on both individual and community while, at the same time, providing much needed economic and healthcare supports.

The Social Security Administration (SSA) oversees SSI and SSDI benefit programs for people with physical and/or mental disabilities. For people with disabilities who are homeless, the immediate gains of SSI and SSDI are clear: a steady income and health insurance. SSA disability benefits, however, provide more than these obvious economic benefits. Having SSI and/or SSDI brings them a step closer to accessing stable housing, treatment, and support services. SSA also strongly supports beneficiaries returning to or beginning employment through several work incentive programs.

Despite the benefits to individuals and communities, many homeless people, particularly those who are chronically homeless and have mental illnesses or other disabilities, do not receive SSA disability benefits. It is estimated that two-thirds of people who are chronically homeless have one or more serious health or behavioral health problems. Many likely would be eligible for SSA benefits; however, only 11 percent of the homeless population is estimated to receive SSI.²

There are many reasons why eligible people do not receive benefits, but chief among them are:

- They are not aware of the programs.
- They have difficulty completing the application due to the effects of their illnesses.
- They have difficulty interacting with SSA staff and following an application through the process.
- There are factors related to homelessness that inhibit the application process: e.g., lack of a permanent address, lack of medical records, transient medical care, lack of personal identification.
- Factors related to mental illness—e.g., stigma surrounding mental illness, a symptomatic denial of the illness, the less objective nature of diagnosing illness and determining severity—also inhibit the process.

However, it does not have to be this way. Successful programs have achieved approval rates close to 100 percent at the initial application stage for applicants they felt met SSA's disability criteria. In addition, when assisting applicants about whose status they were less sure, these programs still had a success rate

¹ Culhane, D. Dynamics of Homelessness, and the Impact of Supportive Housing on Services Use and Cost. *Journal of Social Distress and the Homeless*, Date??

² Rosen, Jeremy, Rebecca Hoey and Teresa Steed. Food Stamp and SSI Benefits: Removing Access Barriers for Homeless People, *Journal of Poverty Law and Policy*, March-April 2001: 679-696.

equaling or surpassing the national average for all applicants (37 percent).³ Overall, these programs have achieved approval rates on the initial determination of between 65 and 85 percent.

What Works...Key Qualities for Success

As communities are increasingly aware of the costs of homelessness, they are prioritizing the effort to expedite SSA disability benefits for eligible people. Staff working in these programs become knowledgeable about the process used by SSA and the state-level Disability Determination Services (DDS)⁴ agencies to make disability determination decisions for SSA. Many of these initiatives employ strategies that can help other communities enhance access to SSA disability benefits as part of their efforts to end chronic homelessness.

What does it take to make a difference?

While the specifics of successful SSI initiatives vary, several elements of these programs are known to contribute to their effectiveness:

- **Strong, willing leadership**
- **Appropriate staffing**
- **Use of promising practices**
- **Ongoing training and quality control**
- **Collecting and reporting on outcomes**
- **Innovation**
- **Collaboration**

Promising Practices

Focus on Initial Applications
Become an Applicant's Representative
Use Consultative Examinations (CEs) Effectively
Foster Relationships with Healthcare Providers
Open Communication with SSA and the DDS
Create a Summary Report
Establish Representative Payee Services

In the following pages, programs illustrating these elements of success are described so that others might identify approaches that can be replicated or adapted for use in their own agencies or communities.

Strong, Willing Leadership

To reach their potential, SSI initiatives need strong leadership. All the programs featured here were started because someone in a leadership role recognized the potential and followed through to make it happen. Leadership is needed to bring resources to the table and create the collaborations necessary to support the work of staff who assist homeless applicants for SSA disability programs. Leaders can use the outcomes and strategies described in this report to reach out to other leaders and build a larger network of support.

Appropriate Staffing

Any effort to prioritize SSI outreach will probably require an increase in staff time to accommodate the increased work demands. Existing staff responsibilities can be reconfigured in a number of ways to achieve this, as an alternative to adding positions dedicated exclusively to SSI outreach. For example,

³ It is important to note here that SSA data do not differentiate between those who are homeless and those who are housed. Given the unique barriers that homeless claimants encounter, it is not surprising that their approval rates are lower than this figure, according to comparative studies conducted by DDS in some jurisdictions (e.g., Boston).

⁴ The Disability Determination Services (DDS) is a state agency that contracts with SSA to make the medical determination on disability. There is at least one per state, and they can exist under various state departments. For more information about the DDS, see the section on *Open Communication with SSA and the DDS*.

since assisting people with SSI applications is only one part of its overall work, Jewish Family Services of Atlantic and Cape May Counties (JFS) in New Jersey has a dedicated benefits specialist who assists people with the application process and acts as JFS's liaison with the local SSA office. Focusing on SSA disability benefits allows the specialist to develop expertise and foster a relationship with claims representatives (staff who process applications) at the local SSA office.

Expediting Applications and Recouping State Funds in Washington

The Washington State SSI Facilitation Program began in 1989 as a pilot project to help the state recoup General Assistance (GA) funds. Eligible GA recipients apply for SSI benefits with the help of a social worker from the Department of Social and Health Services' Belltown Community Services Office (CSO). They receive interim GA cash assistance that is reimbursed, through an agreement between state and Federal governments, once SSI benefits are received. These GA recipients also become eligible for expedited Medicaid benefits. The social worker accompanies applicants through the process, including appeals when necessary.

DSHS has developed relationships with physicians and psychologists to conduct medical or psychiatric evaluations and with lawyers who have specialized knowledge of the appeals process and who are willing to represent applicants at the hearing level. Turnaround time averages about eight months (including appeals). At the Belltown CSO, approximately 40 percent of the initial determinations and reconsiderations are favorable, with an additional 15 percent approved at hearing level. More than 15 years later, the program is running strong. As Mark Dalton of the Belltown CSO describes it, "This is big business in Washington State. Our program collects over 20 million dollars a year in reimbursements, which, in turn, help to support our program."

Other organizations have taken a different approach. Heartland Alliance and the Maryland SSI Outreach Project use a team model; every member of the team is trained and has a role in assisting a person not only with SSI but with other service needs. "Since we do a lot of outreach, it doesn't make sense for us to have a single person with all the SSI knowledge," Heidi Nelson of Heartland Alliance in Chicago points out. "Instead, every person in our team is involved in all aspects of a client's service provision."

Positive Resource Center in San Francisco has a Benefits Counseling Program that employs a staff of five attorneys, two legal assistants, and one benefits specialist who work in concert to advocate for and assist applicant's. The staff assists clients from initial application through the hearing and appeals process, if that becomes necessary. They assist over 700 clients a year; last year alone they had an 85 percent approval rate over the three levels (initial application, reconsideration, and hearing). Jane Gelfand, the program's director, feels that attorneys are best able to "navigate the complex legal, medical, and advocacy structures that surround benefits acquisition."

Although successful SSI outreach efforts may be staffed or organized differently, each has developed a structure that works for them.

Use Promising Practices

By using strategies that others have identified as key to their success, organizations can jumpstart their SSI outreach efforts and begin to see results sooner.

- **Focus on initial applications**—On average, only 37 percent of initial determinations are favorable. On reconsideration, this rate rises to about 52 percent. Subsequent hearings and appeals can reverse unfavorable decisions, but the adjudication process is lengthy and can take years. By focusing on improving documentation of impairment in the initial application, organizations are able to offer more effective and timely service to their clients. The average turnaround time for an initial determination is about three and a half months. The sooner a person receives benefits, the sooner he or she can receive cash assistance and health insurance coverage, which can improve his or her access to health care and housing. When people who are homeless receive SSI and/or SSDI, state or local governments may be able to recover costs for GA or interim health insurance.

Making It Work in Maryland

The Maryland SSI Outreach Project, initiated in 1993 with a one-year SSA demonstration grant, was designed to reduce obstacles that homeless people with mental illness face when applying for SSI:

- Mental illness makes navigating the complicated application process more difficult.
- Stigma surrounding mental illness affects people's willingness to acknowledge it.
- People who lack a fixed address have difficulty keeping and organizing paper records.

The project has a waiver from SSA that awards presumptive disability to homeless adults based on the recommendation of a psychiatric social worker (clinician director), authorized by a physician's signature. The SSI outreach team includes two case managers, a clinician director, and an administrative assistant and has a annual operating budget of \$190K. The team was trained by SSA to complete the application on an outreach basis. During the process, case management staff also provide direct assistance to help people access needed services and housing.

The SSI Outreach Project focuses on getting approvals at the initial stage of disability determination. The staff's belief is that expending the effort up front for every applicant ultimately reduces the time and overall effort necessary to acquire benefits, which helps the individual, the project, SSA and the DDS, and the community.

To help the DDS make an accurate determination, the team creates a *medical summary report* that is signed by a consulting psychiatrist and submitted with the application. They have developed a large network of collaborating partners, including psychiatrists, medical records departments, and other homeless, mental health, and housing service providers. Since they began, 65 percent of all applicants and 95 percent of presumptive disability applicants have been approved upon initial application.

- **Become an applicant's representative**—One common reason for a denial is that SSA and the DDS cannot reach the applicant, often to request more information such as additional medical records or a consultative examination. To avoid this, a case manager can become an applicant's representative.⁵ This is an approach used by many SSI initiatives, such as the Maryland SSI Project, Clackamas County Social Services in Oregon, and JFS. Becoming an applicant's representative is a simple process that opens communication channels among the case manager, SSA and the DDS. The case manager receives a copy of every written communication that SSA and the DDS send to the applicant and, if the application is denied, has access to the applicant's file, in the event that a request for reconsideration/adjudication is deemed appropriate. In addition, SSA and the DDS are much freer to discuss the progress of an application. To become an applicant's representative, a case manager must

⁵ A *representative* is not the same as a *representative payee*. Managing an applicant's financial matters is *not* the role of a representative. Instead, the representative-applicant relationship is one in which the representative officially accepts the responsibility of handling all aspects of the applicant's claim. For more information, see www.ssa.gov/representation.

submit SSA-1696 Appointment of Representative form to the local SSA office where the application is on file.⁶

- **Use consultative examinations (CEs) effectively**—The DDS uses consultative examinations (CEs) only when they need more information about an applicant to make a determination. Most often, CEs are performed by a physician or psychologist of the DDS's choosing who conducts the requested series of tests.

There are two potential problems with this process.

The requested battery of tests often is not sufficient to gather the complete information necessary to make an accurate determination. This paucity of evidence can lead to an initial determination that does not account for the person's full disability. The applicant then must appeal the determination, a lengthy, difficult process.

Creating New Tools in Louisiana

After witnessing the struggle of both case managers and DDS disability examiners to gather and interpret medical evidence, employment history, and personal history to make appropriate, accurate determinations, Brian Byrd had an idea to simplify the process. Innovative Health Care Strategies and the Disability Eligibility Information Management System (DEIMS) software is a project of the Louisiana Office of Mental Health and Volunteers of America in Baton Rouge, LA.

The DEIMS software is a program that case managers can use when working with an applicant. Guided by a series of interview questions, case managers ask applicants about their personal, educational, employment, and medical histories, entering the answers into the program. From these answers, the program produces a comprehensive, two-page report that can be edited which describes the disability and illustrates its link to an applicant's ability to work. It also can create an SSA-3368 Disability Report (one of the forms required for a SSI/SSDI application) from the entered information.

The software can track each application's progress and provide a cumulative record of SSI/SSDI claims facilitated by the agency. Since 2002, the software has helped case managers file more than 1000 applications with an approval rate for initial submissions at more than twice the national average.

In addition, the consultant usually is not familiar with the applicant and lacks information about his or her treatment history. This can be a problem, particularly for an applicant who is homeless and who has a mental illness. He or she may not be symptomatic during the CE, may deny his or her illness, or may make a special effort to present well. If the consulting physician or psychologist does not see evidence of a disability, he or she cannot diagnose one.

There are, however, strategies for dealing with this dilemma. The first is to avoid the DDS CE process altogether. CEs are not required if there is sufficient medical evidence of disability from a treating provider. Yvonne Perret, former executive director of the Maryland SSI Outreach Project, finds the most effective solution is to collaborate with a physician who is willing to work with applicants over a period of time to develop an accurate diagnosis. By working together to produce a comprehensive picture of the person's disability and how it affects their ability to work, the need for a CE can be reduced or eliminated.

⁶ As an alternative to a case manager becoming an applicant's representative, an applicant can grant the case manager access to his or her SSA records through Release of Information forms and, thus, authorize communication between SSA and the case manager. While this arrangement does not carry the responsibility of representative, it also does not allow the level of open communication that being an applicant's representative does.

If a CE is required, there are ways to ensure it is effective. Mark Dalton of Washington's Belltown Community Services Office (CSO) has helped his team develop a "cache of practitioners authorized by the DDS to conduct CEs. Most doctors are good at diagnosing illnesses, which is very different from documenting how a person's illness affects his or her employability." At the Colorado Coalition for the Homeless, all CEs are done in their own facilities, which include the Colorado Health Care for the Homeless program. This makes the applicant feel comfortable and helps ensure that he or she attends the CE. However this is achieved, it is important to avoid a less personal CE process, conducted by a practitioner who is inexperienced in dealing with individuals who are homeless.

- **Foster relationships with healthcare providers**—Healthcare providers, such as physicians, hospitals, and community health centers, are important allies and collaborators in any effort to increase access to SSA disability benefits. Community providers that do not directly provide medical services need to establish relationships within the medical community to help develop evidence of an applicant's disability. Healthcare providers also benefit from such collaborations, since SSI beneficiaries generally receive Medicaid support which pays for healthcare services otherwise not reimbursed. In addition, once a beneficiary receives Medicaid, providers can recoup expenses for medical care given within the past _____ months.

Health Care for the Homeless providers often offer both health care and case management services. These agencies have a distinct advantage because they have an in-house capacity both to develop the medical evidence necessary to document an applicant's disability and to provide assistance in completing and filing the application. Community mental health centers (CMHCs) may also be important collaborators. Many CMHCs receive PATH funding from their state mental health agency to provide outreach and case management services to people who are homeless with mental illnesses and/or co-occurring disorders.

Health and behavioral health care providers can help in several ways:

Cause for HOPE in Denver, Colorado

When Dan Reardon began working as a volunteer at the Colorado Coalition for the Homeless (CCH), he was the benefits acquisition team. When CCH received one of SSA's HOPE grants in 2004, the Benefits Acquisition and Retention Team (BART) program became a full-fledged department, including Reardon as project director, a physician, psychiatrist, an occupational therapist, a case manager, and a data specialist. They now have an advisory board, consisting of BART members, representatives from the regional and local SSA offices, a DDS professional relations officer and disability examiner, a manager from the Office of Hearings and Appeals (OHA), members of a partner agency that conducts homeless outreach, and three consumers.

BART team members assist clients with the application, which they complete together and submit to the local SSA office. They also compile a complete medical evidence package, which is sent with the application. The application is flagged and expedited by SSA, the DDS, and even the OHA in instances when a hearing is necessary. Due to relationships the BART has developed, they have open communication with SSA and the DDS, who will contact them when further information is needed to make a determination. This open and expedited communication process has shown great success, even in its first year, with 75 percent of initial applications approved and time to approval averaging 40 days, with a maximum of 90 days.

Develop medical evidence—Developing medical evidence for a disability determination is different from making a diagnosis or recording symptoms and treatment history. The connection between the person's impairment and his or her inability to work must be explicit. The distinction is one that many physicians and psychologists do not recognize, which can result in insufficient medical evidence required for disability determinations. When a case manager or agency works with the same

practitioners over time, however, both parties learn what the other needs to provide complete and effective medical evidence to DDS. Mark Dalton, an administrator with the Washington State Department of Social and Health Services's Belltown Clinic, credits the clinic's relationship with a group of practitioners that understand the DDS's disability determination process as one of the keys to the program's success.

Conduct consultative examinations—As discussed above, when a physician or psychologist knows what medical evidence the DDS disability examiner requires, he or she can conduct an examination tailored to produce that information. A physician or psychologist who can present a longitudinal history of the applicant's impairment(s) and who is aware of DDS' requirements is a tremendous asset.

Deliver medical records—Along with a physician or psychologist, the medical records department of local healthcare facilities can help provide necessary information about an applicant. Often, constructing a longitudinal history of an applicant who is homeless is a challenge. Piecing together an applicant's medical records can be difficult when medical treatment has been provided at a number of different facilities over time. Once medical records are located, the medical records department staff needs to know what information to send to DDS. If a case manager is able to collaborate with the medical records staff in area healthcare facilities, this search can be much easier. When discussing

collaboration with a medical records administrator, it is useful to have information that shows how this effort will benefit not only the individual applicant but the health care facility housing the medical records as well. The Maryland SSI Project has such arrangements and also offers to copy the records (with the proper releases of information in hand) in order to reduce the burden on short-staffed medical records departments. Once established, this arrangement is often welcomed by these departments.

DDS Takes a Lead Role in Boston

In response to barriers identified for people who are homeless, a special unit was started in the Boston Disability Determination Services (DDS) in 1985 to handle all disability determinations for applicants who are homeless. When an application is filed at the local SSA office for a person who is homeless, the application is flagged and assigned directly to the DDS homeless unit. The flagged file assures that the application is dealt with promptly by disability examiners and doctors in the unit who are well versed on homeless issues.

The unit encourages presumptive disability, which allows applicants to begin receiving benefits based on the presumption that they will be found disabled once the usual process is complete. In addition, the unit expedites consultative examinations when necessary.

In 2004, a DDS employee began visiting area shelters twice a week to assist with applications. The DDS homeless unit supervisor provides trainings to shelter staff regarding SSA disability programs and the application process. The Boston DDS also actively encourages relationships with agencies throughout the state. They work in conjunction with an advisory board made up of DDS employees, advocates, and consumers and actively participate on board's subcommittee on homelessness.

- **Open communication with SSA and the DDS**—Many mental health or homeless service agencies are developing relationships with local SSA and DDS staff to try new ideas for working with applicants who are homeless and who have mental illnesses. Local SSA offices can implement steps to make the initial application process easier, while the DDS staff can work with SSI programs to ensure applications are complete initially. In addition, programs can collaborate with both SSA and the DDS to expedite the application process. As Dan Reardon, Benefits Acquisition Retention Team (BART) coordinator for the Colorado Coalition for the Homeless, states, "One of the most important steps we took was to

reach out to our regional and local SSA and DDS offices. SSA buy-in has made everything possible.”

Dedicated staff—Local SSA and DDS offices can dedicate staff to work with applicants who are homeless. Boston’s DDS has a special unit that works on all determinations for applicants who are homeless. This allows DDS staff to expedite applications for homeless persons because they become experts in the nuances of such determinations.

Flagged applications—One way that local SSA and DDS staff can help to expedite the application process is to flag applications of people who are homeless. Flagged applications can be more easily identified for prioritized determinations. Partnerships between agencies and local SSA and DDS offices have been successful in many parts of the country, including Colorado, Massachusetts, and Rhode Island.

Innovative pilot programs—SSA and the DDS have the authority to make things happen. Ultimately, it was open communication with them that helped define programs and initiatives like the pilot program that eliminates the reconsideration phase of the appeals process; the Maryland SSI Outreach Program where outreach workers were trained and equipped to take application directly on the street; the Joint Access to Benefits pre-release program in Multnomah County, Oregon, that brings SSI outreach into correctional facilities; and the DDS’s Homeless Unit in Boston.

- **Create a summary report**—In applications for SSI/SSDI, there is often a critical gap between the information provided by medical and non-medical sources and the information needed by DDS to make a disability determination. Physicians and psychologists are trained to determine a patient’s diagnosis(es); the DDS is looking not only for diagnoses, but for how impairments resulting from the diagnosed condition(s) affect a person’s ability to work. Effective SSI outreach finds ways to close this gap.

Many case managers and benefits specialists, including those at the Maryland SSI Outreach Project and JFS, write a *medical summary report* about each applicant. In lay language, the case manager or other clinician outlines the applicant’s personal, medical, and employment histories in a single document, tying the diagnosis and resulting impairment to the person’s ability to work. References to the applicant’s medical records, as well as third-party evidence such as testimony of family and friends and the case manager’s own observations, help to support this evaluation. This report is submitted to the DDS along with the rest of the application. Whenever possible, the report is co-signed by the applicant’s physician or psychologist. Although the summary report is important whether a physician signs it or not, *without a physician’s or psychologist’s signature it does not constitute medical evidence, a fact that can be crucial to DDS’ determination.*

Laura Rogers of JFS credits the use of the medical summary report with a marked “decrease in turnaround time and more initial approvals.” The Disability Eligibility Information Management System (DEIMS) software, developed jointly by the Louisiana Department of Mental Health and Volunteers of America, can be used to create a summary report (see box on p. 5).

- **Establish representative payee services**—While not part of the initial application process, representative payee services are a critical support for many beneficiaries; to not consider how they will be established in the initial SSI initiative planning would be negligent. For people who are homeless and who have mental illness or co-occurring disorders, assistance with money management, once benefits are received, is often a good idea. SSA may require a person to have a representative payee—a person or agency who helps the beneficiary manage his or her benefit payments, expenses, and other financial matters. But regardless of whether SSA requires a payee or not, organizations may want to offer money management services until an individual’s skills in this area improve. Successful

SSI outreach initiatives either handle representative payee and money management services in-house or collaborate with a trusted representative payee program.

Ongoing Training and Quality Control

Heidi Nelson and Ed Stellan of Heartland Alliance in Chicago credit two things for the success of their program: collaboration and *training*. Ongoing training is crucial to the success of any effort to increase access to SSA disability benefits. As Mark Dalton states, “You need experienced, knowledgeable staff. Helping people apply for SSI benefits is not easy. The people can be challenging and the documentation process takes time and good detective work.” Knowledgeable, experienced case managers or benefits specialists often do more than assist individual applicants. They often become the strongest advocates behind agency or community-wide efforts for more effective SSI outreach.

Collaborating to Bring Training to Providers in Virginia

Led by Michael Shank and Sarah Paige Fuller, PATH (Projects for Assistance in Transition from Homelessness) program directors in the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) are working to improve access to SSA disability benefits for people who are homeless and who have mental illness. Beginning in 2003, they provided statewide training for mental health and homeless service providers. Yvonne Perret, former executive director of the Maryland SSI Outreach Project and developer of SAMHSA’s *Stepping Stones to Recovery* training curriculum, conducted four regional trainings on the application process and strategies for creating more effective applications.

Following these trainings, DMHMRSAS staff worked with the Virginia Department of Rehabilitative Services to produce a series of four additional trainings, which brought together experts from the State, including representatives from SSA and DDS. Since the trainings, attendees have reported an increased level of involvement with SSI, more comfort working with clients on applications, and a greater knowledge of the intricacies of the application process.

There are many training resources available to community mental health centers and homeless service agencies—within experienced agencies, within the community at large, and within SSA and the DDS. In addition, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has recently completed a case manager training curriculum, an accompanying train-the-trainer curriculum, and a reference guide as part of their *Stepping Stones to Recovery* series, designed to enhance access to SSI for people who are homeless.⁷

An agency may have a benefits specialist or clinician who can share knowledge and experience with others. Some programs, such as the Colorado Coalition for the Homeless, do regular in-service trainings to keep their staff up-to-date. Several local and state governments have developed trainings or have brought in trainers for local providers to present information on SSA disability benefits and the application process. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services brought a series of trainings to case managers, administrators, advocates, and other interested parties throughout the state. Since that time, participants report increased knowledge about SSI, comfort with the application process, and new skills.

⁷ Substance Abuse and Mental Health Services Administration. (Working Draft, 2004) *Stepping Stones to Recovery*. Rockville, MD: SAMHSA.

As the people involved in making disability determinations, SSA and DDS staff have a wealth of information that homeless assistance providers may find useful. They can provide training on the many intricacies of the disability application process: filling out and filing the various application forms, income and resource requirements, and the appeals process, to name a few. Most importantly, they can provide information on what exactly they look for when making determinations. The Community Partnership for Southern Arizona (CPSA, brought in two professional relations officers from the Arizona DDS to provide trainings throughout the state. Barbara Montrose, the CPSA Housing and Homelessness Specialist, credits them with “demystifying and simplifying the process. They answered questions, dispelled some of the common myths about determinations, and even gave out their contact information so that people could ask questions later.” The assistance, she says, has been invaluable.

Training also can be extended beyond the agency staff to include other key stakeholders. For example, programs that have relationships with healthcare providers can train those providers to document impairments more effectively. Correctional facility employees who work with pre-release programs can also benefit, as can local and state agency administrators.

Using Data to Make the Case in San Francisco

Maria X. Martinez, deputy director of community programs at the San Francisco Department of Public Health (DPH), will tell you that the SSI Advocacy Workgroup was started because “there were so many systems-level issues to overcome and so much tension between the various players that needed to be resolved.” The Workgroup was convened to bring together key stakeholders in local government, the advocacy community, and the mental health and homeless services community to increase access to SSA disability benefits.

Since 2001, the Workgroup has fostered relationships between community agencies and outreach programs, advocated to city government for systems change, and compiled materials to help direct service providers access the information and resources they need.

One of their largest undertakings has been collecting and analyzing cost-benefit data on their SSI outreach efforts. During their first year, each client who received benefits cost the DPH \$3000 in advocacy money. However, the DPH was able to recoup \$20,000 for each client in Medicaid and GA monies. They estimate the return on providing SSI outreach services to be around \$6 for every \$1 spent for the City. They have used these figures to convince key stakeholders of the need for SSI outreach, and the Workgroup’s success in rallying support has been a model for the benefits of outcome-based data collection.

Collecting and Reporting on Outcomes

One barrier to starting an SSI outreach effort is convincing key stakeholders within an agency, as well as in the larger community, that such an effort is worth the resources necessary to make it happen. Providing evidence of past successes and cost savings to stakeholders is one way to convince them of a program’s potential value. In San Francisco, the Citywide SSI Advocacy Workgroup compiled data that documented the bottom line financial benefits that the city could expect. They were able to show that during the first year alone, savings realized as a result of SSI advocacy services were five times greater than the amount expended for those services. Data can help make an already good argument that much stronger.

Innovation

Although SSI outreach efforts may employ different strategies to accomplish the same goals, a common denominator among them is the ability to see beyond current methods and try new ideas. In Louisiana, Brian Byrd saw a need for a more efficient way to provide complete, accurate information to the DDS, and he helped to develop the software to accomplish it. In Maryland, Yvonne Perret and the Maryland SSI Outreach Project team saw that bringing applicants to SSA was not working, so they convinced SSA to allow them to complete applications and recommend clients for presumptive disability as part of their

street outreach. Liv Jenssen of JAB sums it up: “You have to keep an open mind. Try new things and just keep beating the drum. You must be the cheerleader because you are the one who can help.”

Collaboration

Collaboration is critical to any successful effort to increase access to SSA disability benefits. The process of applying for, receiving, and maintaining SSI benefits is one that involves many different organizations and people within a community. It makes sense that that process can be improved by opening communication and fostering cooperation among those key stakeholders. Regardless of a program’s role in the process—as service provider, hospital, correctional facility, state mental health office—a collaborative perspective is required to create a strong, community-wide outreach initiative.

Correctional Facilities

Correctional facilities are another collaborative possibility. Connecting ex-offenders to services, including SSA disability benefits, can reduce recidivism rates. This, in turn, can help prisons or jails reduce costs. Collaborations with correctional facilities often focus on providing pre-release services.

- **Pre-release programs**—While incarcerated persons typically wait to apply for benefits until they are released from prison or jail, an application for SSI benefits can be filed 30-90 days prior to release. Documentation of the applicant’s disability can begin much earlier so that a complete application can be filed as soon as possible. Programs such as Oregon’s Joint Access to Benefits (JAB) and Legal Action in Wisconsin have developed successful pre-release programs with several correctional facilities. Such programs are often welcomed by SSA, which has a process for setting up pre-release agreements. These agreements are crucial to prevent recidivism and exacerbation of impairments. As

Liv Jenssen, program manager for JAB, puts it, “If clients are unable to receive benefits within a reasonable timeframe, they are left with few options; many return to jail or prison, or their chronic homelessness and disabling condition worsens.” By working with staff, benefits specialists, physicians and psychologists, and social workers within the correctional facility to screen for eligible people and to assist them through the application process, agencies can work to reduce the difficulties encountered upon release.

Pre-Release Outreach in Multnomah County

Joint Access to Benefits (JAB) was started to initiate the SSA disability application process for individuals to be released from incarceration in Multnomah County, Oregon, or for those who have been released and are homeless. JAB is a collaborative project between the Multnomah County Department of Community Justice’s Transition Services Unit, the State of Oregon Departments of Corrections and Human Services, Multnomah County’s Sheriff’s Office, the Department of County Human Services, and the SSA district office.

Much of JAB’s work is done inside correctional facilities. The application process is initiated six months prior to release. JAB staff work with social workers inside the correctional facilities to complete the application by phone. The application is then flagged as a JAB file and expedited through the process so that the applicant can begin receiving benefits as soon as he or she is released. To facilitate this process, Liv Jenssen of JAB has developed relationships with the County, SSA, and DDS staff. In 2004, JAB submitted 79 applications of which 90 percent were approved.

Local and State Governments

Government, whether local or state, can play a role in creating a successful SSI outreach initiative. Many effective programs either originate within a government agency or are able to attract the support of government officials. The most important role a government can play is to develop the infrastructure and coordination, intervene to reduce complexity wherever possible, and foster the support to begin and sustain an effort to increase access to SSA disability benefits. This can involve several strategies:

- **Create partnership opportunities**—Many successful SSI initiatives have been developed through partnerships between government and community agencies, including those in Washington State; Savannah and Atlanta, Georgia; Franklin County, Ohio; and Broward County, Florida. For example, the Department of Social and Health Services (DSHS) in Washington has teamed with the Belltown Clinic for more than 15 years in a highly successful SSI outreach effort. The DSHS has been able to facilitate the development of a complex network of social workers, clinics, outreach teams, physicians, lawyers, SSA claims representatives, DDS disability examiners, and other key people. All these groups work together with the Belltown Clinic and the DSHS to increase access to SSA disability benefits.
- **Create an internal program**—While some programs have been developed through external partnerships, others have found success working from within. Clackamas County, just south of Portland, Oregon, for example, was awarded one of 41 SSA HOPE grants in 2004 to help people access SSI benefits more effectively. The County Social Services agency has designed its own SSI HOPE Project unit that works directly with people on their SSI applications, guiding them through the process.

Conclusion

SSA disability benefits are powerful tools in the struggle to end chronic homelessness for people with disabilities. Organizations around the country are recognizing this and creating opportunities to help people access these benefits. The programs highlighted here all have adopted strategies to assist the homeless people in their communities. By sharing what they have learned and encouraging others to “beg, borrow or steal” their promising practices, access to SSA disability programs can be enhanced, chronic homelessness can be reduced, and state and local governments can realize cost savings.

Contact Us

If you have an SSI outreach program or promising practice that you would like to share with others, please contact Deborah Dennis, Policy Research Associates, ddennis@prainc.com.

For more information on the programs featured here...

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